Codify
BY AAPC

Outpatient Facility Coding Alert

Reader Question: Use Modifier 59 When CMS Bundles the Procedure

Question: Our physician performed an EGD with guide wire dilation and also biopsy on a patient recently. How should I bill these sessions? Do I need modifiers on these codes? They are not bundled but have been denied in the past without modifier 59 because I was basically told these were in the same "family" and couldn't be billed together. What should I do?

Alabama Subscriber

Answer: For the upper GI EGD and guide wire esophageal dilation, you should report code 43248 (Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator[s] through esophagus over guide wire). For the GI EGD with biopsy, you should report code 43239 (Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple).

You should apply modifier 59 (Distinct procedural service) only when CMS or CPT® normally bundle the procedures, but you need to indicate that the physician performed those procedures at separate (and thus non-bundled) locations or sessions. CCI edits do not show bundling issue between these codes. You should ask your insurance company to provide policy or documentation, as to why they are denying it. Also, a few payers have been paying these code combinations with modifier 51 (Multiple procedures).

Whether you should use modifiers on your multiple EGD claim will also depend on the situation. You may be tempted to append modifier 59 to each multiple EGD claim without even thinking about it. However, if you're not sure that every payer wants modifier 59 on a multiple EGD claim, you should not report it. Modifier 59 is always the modifier of last resort.